

VILLAGE OF DOWNERS GROVE
Report for the Village Council Meeting
10/5/2021

SUBJECT:	SUBMITTED BY:
Employee Benefits Renewal Contract and Medical Plan Amendments for FY2022	Lauren Linares Director of Human Resources

SYNOPSIS

Resolutions have been prepared to authorize approval of employee benefit renewal contracts and plan amendments for FY22.

STRATEGIC PLAN ALIGNMENT

The goals for 2021-2023 include *Steward of Financial, Neighborhood and Environmental Sustainability*.

FISCAL IMPACT

The proposed FY2022 health insurance budget includes \$1,114,539 for claims administration, stop loss contracts and Wellness Health Initiative. The vendors and contract amounts for FY2021 and FY2022 are itemized below:

Vendor	Contract Item	FY2021 Amount	FY2022 Amount
Blue Cross Blue Shield	Medical Claim Administration & Specific and Aggregate Stop Loss	\$879,347	\$731,252
National Insurance Services Trust	Life Insurance	\$83,504	\$-
Blue Cross Blue Shield	Life Insurance	\$-	\$80,047
National Insurance Services Trust	Disability Benefits	\$26,746	\$-
Blue Cross Blue Shield	Disability Benefits	\$-	\$24,732
Humana	Retiree Carve Out	\$324,887	\$269,232
Professional Benefit Administrators	COBRA & Flexible Spending	\$9,276	\$9,276
Total		\$1,323,760	\$1,114,539

RECOMMENDATION

Approval on the October 5, 2021 consent agenda.

BACKGROUND

The recommended contracts provide the necessary administration and support for the Village's Health Insurance program, which has a total budget of \$7.8 million as shown in the FY2022 Proposed Budget. The budget also describes how the Village has positioned itself well to effectively control health insurance costs and respond to the requirements of the Patient Protection Affordable Care Act.

A summary of the 2022 employee benefits contracts is provided below:

- *Medical Claim Administration* – The Village has a self-funded medical plan and contracts with an outside vendor to provide claim administration on behalf of the Village. Claim administration includes medical and prescription drug claim adjudication, pre-certification and medical case management services. On an annual basis, staff reviews the claim administration services received from the vendor. Also reviewed is the relationship the vendor has with Preferred Provider Organizations (PPO) to ensure the discounts received through the PPO contracts are cost effective to both the employee and the Village. The Village has contracted with Blue Cross Blue Shield of Illinois for these services since 2011. Blue Cross provided a renewal quote for 2022 for claims administration. Blue Cross also charges a fee to access their PPO network. The fee is offset by the significant savings the Village realizes through the Blue Cross PPO discounts. The Village made positive changes to the plan design, which was recognized by Blue Cross, who provided a more positive renewal cost, which includes a deeper credit for our Wellness Screening initiative and increased credits in pharmaceutical rebates. Total annual costs for medical claims administration for 2022, which includes a discount for packaging our life insurance and disability benefits with BCBS, are credited in the amount of \$134,677. This represents a savings of \$198,063 from the previous year.
- *Stop Loss Coverage* – The Village purchases stop loss coverage to limit its financial exposure. Stop loss coverage provides insurance for catastrophic medical claims of participants in the Village's group health care plan. There are two types of stop loss coverage, specific and aggregate. Specific stop loss insurance provides a point at which time the insurance company becomes responsible for any claims after an individual insured reaches a pre-determined limit in the contract year. As part of the annual review, staff directs the Village's consultant, the Horton Group, to recommend to the Village the most appropriate point for specific stop loss coverage. The consultant reviews specific claim data on the Village's group and determines if it is cost effective for the Village to take on additional claim exposure. For 2022 the consultant determined that the Village should remain at the current \$150,000 specific stop loss level. Due to Blue Cross anticipating a negative market reaction, the Village expects an increase in the Stop Loss premium. The Village does obtain alternative quotes on stop loss coverage on an annual basis. Blue Cross's quote for stop loss totals \$865,929 annually. The increase of \$49,968 for stop loss from last year is due to market estimates based on Village demographics. Instead of red lining individuals at higher levels of stop loss at a higher rate, the underwriter added to the premium and kept all participants at \$150,000 stop loss, which is in the best interest of the Village's Health Plan.
- *Life Insurance* – Life Insurance is offered as an employee benefit. This year, in order to reduce administrative fees, the Village is changing vendors, from National Insurance Services to Blue Cross Blue Shield. The premium for Life Insurance for 2022 is \$80,047. This premium reflects a savings of \$3,457 from the previous year.
- *Long Term Disability Insurance (LTD)* – LTD is a benefit for all full time employees, except sworn Police or Fire employees, who are covered through the pension plan. In 2022, it was decided to change

vendors to Blue Cross Blue Shield, in order to reduce administrative fees. The premium cost for FY22 is \$24,732. This premium reflects a savings of \$2,014 from the previous year.

- *Retiree Carve Out* – Village employees and their eligible spouses that are on the Village’s Health Insurance Plan go to the Retiree Carve Out when they reach Medicare age at 65 years old. In 2012 the Village, through its Broker, found a Humana Supplement plan where the coverage for these retirees is provided and are no longer on the Village’s Self-Insurance Program. The Village pays the premium and invoices those premiums to the respective retirees. However, employees that retired prior to the change in Village Ordinance on 9/9/2009, receive a credit of 50% of premium. The premium for 2022 is \$269,232. The decrease from the previous year, totaling a savings of \$55,655, is due to additional vendors entering the competitive Medicare market.
- *Professional Benefit Administrators (PBA)* – PBA provides flexible spending accounts for Village employees and administers COBRA for separating employees. The FY2022 fee is \$9,276.

ATTACHMENTS

Resolutions
Contracts

RESOLUTION NO. ____**A RESOLUTION AUTHORIZING EXECUTION OF A RENEWAL AGREEMENT BETWEEN THE VILLAGE OF DOWNERS GROVE AND BLUE CROSS/BLUE SHIELD OF ILLINOIS FOR MEDICAL CLAIM ADMINISTRATION SERVICES**

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Administrative Services and Claim Administrator Agreement Renewal (the "Renewal"), between the Village of Downers Grove (the "Employer") and Blue Cross/Blue Shield of Illinois (the "Claim Administrator"), for medical claim administration services, effective January 1, 2022 through December 31, 2022, as set forth in the form of the Renewal submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Renewal, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Renewal.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

Mayor

Passed:

Attest: _____

Village Clerk

Benefit Program Application (“ASO BPA”)

Applicable to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, hereinafter referred to as “Claim Administrator” or “BCBSIL”

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 365058

Group Number(s): P65060 P65061

Section Number(s): see account structure

Legal Employer Name: Village of Downers Grove

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN MAY NOT BE NAMED.)

ERISA Regulated Group Health Plan*: Yes No

Is your ERISA Plan Year* a period of 12 months beginning on the Effective Date of Coverage specified below? Yes
If not, please specify your ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

ERISA Plan Administrator*:

Plan Administrator’s Address:

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Non-Federal Governmental Plan (Public Entity) ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? Yes
If not, please specify your Non-ERISA Plan Year*: Beginning Date ___/___/___ End Date ___/___/___ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/day/Year) 01 / 01 / 2022

Anniversary Date: (Month/Day/Year) 01 / 01 / 2023

Account Information

NO CHANGES SEE ADDITIONAL PROVISIONS

Standard Industry Code (SIC): 9111

Employer Identification Number (EIN): 36-6005857

Address: 801 Burlington Ave

City: Downers Grove

State: IL

ZIP: 60515

Administrative Contact: Lauren Linares

Title: HR Director

Email Address: llinares@downers.us

Phone Number: 630-434-5538

Fax Number: 630-434-5484

Wholly Owned Subsidiaries to be covered:

Affiliated Companies to be covered:

Employer Identification Number (EIN):

(Affiliated Companies must be required or permitted to be aggregated per IRS Guidelines, Employer hereby confirms that Employer, Subsidiaries and Affiliates are treated as a single employer under Internal Revenue Code Section 414(b), or (c), or (m) or (o), or under applicable law.)

Blue Access for EmployersSM (“BAESM”) Contact: Pat Charnas

(The BAE Contact is the Employee authorized by the Employer to access and maintain the Employer’s account in BAE.)

Email Address: PCharnas@downers.us

Phone Number: 630-434-5502

Fax Number: 630-434-5484

The Employer or other company listed in this BPA is a public entity or governmental agency/contractor

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

Producer of Record Information NO CHANGES SEE ADDITIONAL PROVISIONS

Effective: _____

If applicable, the below-named producer(s) or agency(ies) is/are recognized as Employer's Producer of Record (POR) to act as representative in negotiations with and to receive commissions from BCBSIL, Claim Administrator's corporate subsidiaries, as applicable, for procuring Claim Administrator's claims administration services for Employer's employee benefit program(s). This statement rescinds any and all previous POR appointments for the Employer. The POR is authorized to perform membership transactions on behalf of the Employer. This appointment will remain in effect until withdrawn or superseded in writing by the Employer.

Are commissions to be paid? Yes No**Producer or Agency to whom commissions are to be paid*:** _____

Illinois Producer#:

NPN:

Address:

City:

State:

Phone:

Fax:

Is Producer/Agency appointed with BCBSIL? Yes No

Commissions:

 PCPM \$ Does a Monthly Cap Apply Yes No \$ (If cap is annual, divide by twelve) Flat \$ Does a Monthly Cap Apply Yes No \$ (If cap is annual, divide by twelve) Percentage of Stop Loss: %

ADDITIONAL COMMISSIONS:

* The Producer or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

Schedule of Eligibility NO CHANGES SEE ADDITIONAL PROVISIONS

Employer has made the following eligibility decisions:

1. Eligible Person means:

- A full-time employee of the Employer.
 A full-time employee of the Employer who is a member of: _____ (name of union)
 A part-time employee of the Employer.
 A retiree of the *Employer*. Define criteria: _____
 Other: Pre 65 Retirees

Are any classes of employees to be excluded from coverage? Yes No

If yes, please identify the classes and describe the exclusion: Any retiree with access to Medicare. In the event a pre 65 retiree loses access to Medicare they are able to come back and be insured under this plan.

2. Employee definitions:**Full-Time Employee means:**

- A person who is regularly scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer.
 Other:

Part-Time Employee means:

- A person who is regularly scheduled to work a minimum of _____ hours per week and who is on the permanent payroll of the Employer.
 Other:

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3. The Effective Date of termination for a person who ceases to meet the definition of Eligible Person:

- The date such person ceases to meet the definition of Eligible Person.
 The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
 Other:

4. Select an effective date rule for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan (The effective date must not be later than the 91st calendar day after the date that a newly eligible person becomes eligible for coverage, unless otherwise permitted by applicable law).

- The date of employment.
 The day of employment.
 The 1st day of the month following 1 month(s) of employment.
 The day of the month following days of employment.
 The day of the month following the date of employment.
 Other:

Is the waiting period requirement to be waived on initial group enrollment? Yes No

Are there multiple new hire waiting periods? Yes No

If yes, please attach eligibility and contribution details for each section.

5. Domestic partners covered: Yes No

If yes: a domestic partner is eligible to enroll for coverage.

If yes, are domestic partners eligible for continuation of coverage? Yes No

If yes, are dependents of domestic partners eligible to enroll for coverage? Yes No

If yes, are dependents of domestic partners eligible for continuation of coverage? Yes No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for domestic partners.

6. Civil Union Partners covered:

- The Employer is an Illinois county, municipality, the State of Illinois, subject to the Illinois School Code, a church plan or other non-ERISA plan. For such Employers, a Civil Union Partner and his or her dependents are automatically eligible to enroll for coverage and, once enrolled, eligible for continuation of coverage as described in the Employer's Plan.

For all other Employers: Yes No

If yes: A Civil Union Partner and his or her dependents are eligible to enroll for coverage.

If yes: Are Civil Union Partners and his or her dependents eligible for continuation of coverage? Yes No

The Employer is responsible for providing notice of possible tax implications to those Covered Employees with coverage for Civil Union Partners.

7. Limiting Age for covered children: Twenty-six (26) years, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. Other:

If Employer is an Illinois county, municipality, the State of Illinois, or subject to the Illinois School Code, this Limiting Age is extended to thirty (30) years, for unmarried eligible military personnel as described in the Employer's Plan.

8. Termination of coverage upon reaching the Limiting Age:

- The last day of coverage is the day prior to the birthday.
 The last day of coverage is the last day of the month in which the limiting age is reached.
 The last day of coverage is the last day of the billing month.
 The last day of coverage is the last day of the year (12/31) in which the limiting age is reached.
 The last day of coverage is the day prior to the Employer's Anniversary Date.

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Will coverage for a child who is medically certified as disabled and dependent on the employee terminate upon reaching the limiting age even if the child continues to be both disabled and dependent on the employee? Yes No

However, such coverage shall be extended in accordance with any applicable federal or state law. *The Employer will notify BCBSIL of such requirements.*

- 9. Disabled dependent:** A disabled dependent means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse.

To administer medical certification of disabled dependents, you may select option (a) Standard Rules or (b) Custom Rules. BCBSIL will administer its standard process for administration of disabled dependent coverage if (a) below is selected by Employer, or at the Employer's direction memorialized below, BCBSIL will follow a customized process if Employer selects (b). If (b) is selected there are additional selections regarding age, proof of prior coverage, certification review, forms, and previous medical certification approvals.

- (a) Disabled dependent administration will follow **Standard Rules**.

A disabled dependent is eligible to **continue** coverage beyond the limiting age, provided the disability began before the child attained the age of 26. A disabled dependent is eligible to **add** coverage beyond the limiting age, provided the disability began before the child attained the age of 26, and proof of coverage as a disabled dependent is provided. Administration of certification review is administered by BCBSIL; a disabled dependent certification form must be submitted to BCBSIL.

- (b) Disabled dependent Administration will follow **Custom Rules**. Please make the following sections:

Age: *Please select one option regarding age of when the disability began.*

- The disability must have begun before the child attained the age of 26.
 All disabled dependents are covered regardless of when the disability began.

Proof of prior coverage: *Please select required or not required below:*

When **adding** coverage, proof of prior coverage as a disabled dependent is required not required.

Certification review: *Please select one option regarding the administration of certification review.*

- Certification review is administered by BCBSIL; a disabled dependent certification form must be submitted to BCBSIL.
 Certification review is administered by the Employer; there are no disabled dependent certification form requirements.

If certification review is administered by BCBSIL, please select one option regarding forms:

- Utilize BCBSIL disabled dependent certification forms.
 Utilize custom/other disabled dependent certification forms.

If Certification Review is administered by BCBSIL, please select allowed or not allowed below:

A disabled dependent approved certification from a prior insurance carrier is allowed not allowed.

A disabled dependent approved certification from a prior BCBS policy is allowed not allowed.

- 10. Will extension of benefits due to temporary layoff, disability or leave of absence apply?**

Yes (specify number of days below) No

Temporary Layoff: 365 days

Disability: 365 days

Leave of Absence: 365 days

However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with an applicable federal or state law. The Employer will notify BCBSIL of such requirements.

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11. Enrollment:

Special Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents within thirty-one (31) days of a Special Enrollment qualifying event if he/she did not previously apply prior to his/her Eligibility Date or when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be the effective date of the qualifying event or, in the event of Special Enrollment due to marriage or termination of previous coverage, then no later than the first day of the Plan Month following the date of receipt of the person's application of coverage.

An Eligible Person may apply for coverage within sixty (60) days of a Special Enrollment qualifying event in the case either of a loss of coverage under Medicaid or a state Children's Health Insurance program, or eligibility for group coverage where the Eligible Person is deemed qualified for group coverage assistance under a state Medicaid or CHIP premium assistance program.

Open Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so, during the Employer's annual Open Enrollment Period. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer. Such date shall be subsequent to the Open Enrollment Period.

Specify Open Enrollment Period: November 1st to November 30th for a January 1st effective date

Late Enrollment: An Eligible Person may apply for coverage, family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when otherwise eligible to do so. Such person's Coverage Date, family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to by the Claim Administrator and the Employer.

Select one of the provisions below:

- Open Enrollment – Late applicants may only apply during Open Enrollment.
 Late Entrant – Late applicants may apply at any time – coverage effective date is determined by the receipt date and the rules governing off-cycle enrollments.

12. * Does COBRA Auto Cancel apply? Yes No

Member's COBRA/Continuation of Coverage will be automatically cancelled at the end of the member's eligibility period.

** Not recommended for accounts with automated eligibility.*

CURRENT EMPLOYEE ELIGIBILITY INFORMATION

Current number of eligible subscribers at onboarding and/or annual renewal 395.

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Lines of Business (Check all applicable services)		<input type="checkbox"/> NO CHANGES <input type="checkbox"/> SEE ADDITIONAL PROVISIONS
<p>Medical Plan Services:</p> <p><input checked="" type="checkbox"/> Participating Provider Option (PPO)</p> <p><input type="checkbox"/> Blue Choice Select PPO</p> <p><input type="checkbox"/> Blue Choice Options</p> <p><input type="checkbox"/> Blue High Performance NetworkSM (Blue HPNSM) without Tiers</p> <p><input type="checkbox"/> Blue High Performance Network with Tiers (Blue HPNT)</p> <p>Additional Services:</p> <p><input checked="" type="checkbox"/> Wellbeing Management</p> <p><input type="checkbox"/> Wellness Incentives</p> <p><input type="checkbox"/> Health Advocacy Solutions</p> <p><input type="checkbox"/> Mercer Health Advantage</p> <p><input type="checkbox"/> Custom Care Management Unit</p> <p><input type="checkbox"/> Blue DirectionsSM (Private Exchange) <i>(If selected, the Blue Directions Addendum is attached and made a part of the parties' Administrative Services Agreement.)</i></p> <p><input type="checkbox"/> Limited Fiduciary Services for Claims and Appeals</p> <p><input type="checkbox"/> Other Select Product</p> <p><input type="checkbox"/> Other Select Product</p> <p><input type="checkbox"/> Other Select Product</p> <p><input type="checkbox"/> Other Select Product</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Other</p> <p>Ancillary Services:</p> <p><input type="checkbox"/> Dental Plan Services</p> <p><input type="checkbox"/> Vision Insurance <i>(if selected, complete a separate application)</i></p> <p><input checked="" type="checkbox"/> Stop Loss <i>(if selected, complete separate Exhibit to the Stop Loss Coverage Policy)</i></p> <p><input type="checkbox"/> Life or Disability Insurance <i>(if selected, complete a separate application for those coverages)</i></p> <p><input type="checkbox"/> COBRA Administrative Services <i>(if selected, complete separate COBRA Administrative Services Addendum to the BPA)</i></p>	<p>Consumer Driven Health Plan:</p> <p><input type="checkbox"/> BlueEdgeSM HCA Administrative Services <i>(if purchased, complete separate HCA BPA)</i></p> <p><input type="checkbox"/> BlueEdgeSM HSA Eligible Health Plan (Vendor: Select Vendor)</p> <p><input type="checkbox"/> FSA (Vendor: Select Vendor)</p> <p><input type="checkbox"/> HRA (Vendor: Select Vendor)</p> <p>Prescription Drugs:</p> <p><input checked="" type="checkbox"/> Covered under a pharmacy benefit <i>(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)</i></p> <p><input type="checkbox"/> Covered under the medical benefit or Blue Script</p> <p>Pharmacy Network (Select one):</p> <p><input type="checkbox"/> Traditional Select Network</p> <p><input checked="" type="checkbox"/> Advantage Network</p> <p><input type="checkbox"/> Preferred Network (Not offered with Blue Script)</p> <p><input type="checkbox"/> Elite Network (Not offered with Blue Script)</p> <p><input type="checkbox"/> Network on PBM Fee Schedule Addendum</p> <p><input type="checkbox"/> Other (please specify):</p> <p>PPO Drug List: Performance Drug List Other (please specify):</p> <p>PPO/HSA Preventive Drug List: Please specify: Select Option</p> <p>Other Rx programs: Please specify: Select Program</p> <p>Prescription Drug Program Clinical Programs</p> <p><input type="checkbox"/> Pharmaceutical Care Management (Retrospective) (Included with HAS)</p>	

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of Illinois.

Custom Care Management Unit is offered by Willis Towers Watson, an independent company, and is administered by Blue Cross and Blue Shield of Illinois.

Medical and Dental benefits and services are administered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Life, Disability and Vision products are issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Illinois is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association, BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Proprietary and Confidential Information of Claim Administrator

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FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this Fee Schedule.

Payment Specifications		<input type="checkbox"/> NO CHANGES		<input type="checkbox"/> SEE ADDITIONAL PROVISIONS	
Employer Payment Method: <input type="checkbox"/> Online Bill Pay <input type="checkbox"/> Electronic <input type="checkbox"/> Auto Debit <input checked="" type="checkbox"/> Check					
Employer Payment Period: <input type="checkbox"/> Weekly (cannot be selected if Check is selected as payment method above)					
<input type="checkbox"/> Semi Monthly (cannot be selected if Check is selected as payment method above)					
<input checked="" type="checkbox"/> Monthly					
Claim Settlement Period: <input checked="" type="checkbox"/> Monthly					
Run-Off Period: Employer Payments are to be made for 12 months following end of Fee Schedule Period. Standard is twelve (12) months.					
Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: months.					
Administrative Per Employee Per Month (PEPM) Charges		<input type="checkbox"/> NO CHANGES		<input type="checkbox"/> SEE ADDITIONAL PROVISIONS	
	Medical				
Administrative Fee	\$60.55	\$	\$	\$	\$
Dental	\$	\$	\$	\$	\$
Limited Fiduciary Services	\$	\$	\$	\$	\$
Advanced Payment Review	25%	%	%	%	%
Health Advocacy Solutions	\$	\$	\$	\$	\$
Wellbeing Management	\$	\$	\$	\$	\$
Management of the Virtual Visits Program	\$52	\$	\$	\$	\$
*Medical Drug Rebate Credit	\$2.50	\$	\$	\$	\$
*Rebate Credit for the Prescription Drug Program	\$73.66	\$	\$	\$	\$
Pharmaceutical Care Management (Retrospective) (No cost if both HAS and Prescription Drug Program are elected)	\$	\$	\$	\$	\$
Commissions: _____	\$	\$	\$	\$	\$
Commissions: _____	\$	\$	\$	\$	\$
Commissions: _____	\$	\$	\$	\$	\$
Other: Product-Related Services List Service: <u>BVA</u>	\$2.50	\$	\$	\$	\$
Other: Select Service Category List Service:	\$	\$	\$	\$	\$
Other: Select Service Category List Service:	\$	\$	\$	\$	\$
Other: Select Service Category List Service:	\$	\$	\$	\$	\$
Miscellaneous:	\$	\$	\$	\$	\$
Miscellaneous:	\$	\$	\$	\$	\$
Total	-\$12.59	\$	\$	\$	\$

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*The Rebate Credit is a per Covered Employee per month credit applied to the monthly billing statement. The Employer and Claim Administrator have agreed to the Rebate Credit and Employer agrees that it and its group health plan have no right to, or legal interest in, any portion of the rebates, either under the pharmacy benefit or the medical benefit, actually provided by the Pharmacy Benefit Manager ("PBM") or a pharmaceutical manufacturer to Claim Administrator and consents to Claim Administrator's retention of all such rebates. The Rebate Credit will be provided from Claim Administrator's own assets and may or may not equal the entire amount of rebates actually provided to Claim Administrator or expected to be provided. Rebate Credits shall not continue after termination of the Prescription Drug Program. Employer agrees that any Rebate Credit provision in the governing Administrative Services Agreement to the contrary is hereby superseded.

Administrative Line Item Charges	Frequency	Amount
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Other: Select Service Category List Service: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Miscellaneous: _____	Select Billing Frequency If applicable, describe other: _____	\$ _____
Total:		\$ _____

Claim Administrator Provider Access Fee(s)	<input type="checkbox"/> NO CHANGES	<input type="checkbox"/> SEE ADDITIONAL PROVISIONS
Group Number(s): P65060, P65061		
<input checked="" type="checkbox"/> % of ADP Savings: 2.33%		
<input type="checkbox"/> \$ per Covered Employee per month: \$		
<input type="checkbox"/> Group with multiple Provider Access Fees by services (e.g., CMM, and/or PPO plans): Group Number(s):		
<input type="checkbox"/> % of ADP Savings: %		
<input type="checkbox"/> \$ per Covered Employee per month: \$		
BlueCard Program/Network access fees: Available upon request.		

Other Service and/or Program Fee(s)	<input type="checkbox"/> NO CHANGES	<input type="checkbox"/> SEE ADDITIONAL PROVISIONS
External Review Coordination: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
<i>If yes</i> , coordination fee: \$700 for each external review requested by a Covered Person that the Claim Administrator coordinates for the Employer in relation to the Employer's Plan.		
Employer elects the following process:		
<input checked="" type="checkbox"/> State of Illinois External Review Process <input type="checkbox"/> Federal Affordable Care Act Process		

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Advanced Payment Review (APR): Yes No

APR is a suite of payment integrity offerings. Refer to the ABS. If Employer elects APR, indicate APR Savings Program or PEPM below:

APR Savings Program

PEPM

For APR capabilities other than Reimbursement Services: If Employer elects APR Savings Program, Claim Administrator will invoice the percentage indicated in the Fee Schedule of any recovered amounts identified by Claim Administrator or third-party vendor other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

Reimbursement Services: Yes No If yes, Claim Administrator will retain twenty-five percent (25%) of any recovered amounts made on third-party liability claims other than recovery amounts received as a result of or associated with any Workers' Compensation Law.

Third-Party Law Firms Provisions (other than Reimbursement Services): Yes No Employer will pay no more than 35% of any recovered amount made by Claim Administrator's third-party law firm or up to 35% of any recovered amount will be deducted from the amount distributed according to established allocation processes.

Alternative Compensation Arrangements: Employer acknowledges and agrees that Claim Administrator has Alternative Compensation Arrangements with contracted Providers, including but not limited to Accountable Care Organizations and other Value Based Programs. Further information concerning Employer's payment for covered services under such Arrangements is described in the Administrative Services Agreement between the Claim Administrator and the Employer.

Virtual Visits Program: Yes No

If yes, Covered Persons would be able to obtain certain Covered Services remotely via interactive video and/or interactive audio/video (where available) capability from Virtual Visits powered by MDLIVE.

MDLIVE® is a separate company that operates and administers Virtual Visits for persons with coverage through Blue Cross and Blue Shield of Illinois. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Termination Administrative Charge

As applies to the Run-Off Period indicated in the Payment Specifications section above:

- i. **For service charges (including, but not limited to, access fees) billed on a per Covered Employee basis at the time of termination of the Administrative Services Agreement or partial termination of Covered Employees,** the Termination Administrative Charge will be the amount equal to ten percent (10%) of the annualized charges based on the service charges in effect as of the termination date or date of partial termination and the Plan participation of the two (2) months immediately preceding the termination date or date of partial termination. Such aggregate amount will be due the Claim Administrator within ten (10) days of the Claim Administrator's notification to the Employer of the Termination Administrative Charge described herein.
- ii. **For service charges (including, but not limited to, access fees) billed on a basis other than per Covered Employee at the time of termination of the Administrative Services Agreement or partial termination of Covered Employees,** the Termination Administrative Charge will be such service charges in effect at the time of termination of the Agreement or partial termination of Covered Employees to be applied and billed by the Claim Administrator, and paid by the Employer, in the same manner as prior to termination of the Agreement or partial termination of Covered Employees.

Other Provisions

NO CHANGES

SEE ADDITIONAL PROVISIONS

1. Summary of Benefits & Coverage:

- a. Will Claim Administrator create Summary of Benefits and Coverage (SBC)?

Yes. Please answer question b. The SBC Addendum is attached.

No. If No, then skip question b and refer to the Administrative Services Agreement for further information.

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

b. Will Claim Administrator distribute the (SBC) to Covered Persons?

- No. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute SBC to Covered Persons (or hire a third party to distribute) as required by law.
- Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and provide SBC to Employer in electronic format. Employer will then distribute to Covered Persons as required by law.
- Yes. Claim Administrator will create SBC (only for benefits Claim Administrator administers under the Agreement) and distribute SBC to plan participants and beneficiaries via regular hardcopy mail or electronically. Distribution Fee for hardcopy mail is \$1.50 per package.

2. Massachusetts Health Care Reform Act:

Does the Employer direct Claim Administrator to provide written statements of creditable coverage to its Covered Employees who reside, or have enrolled dependents who reside, in Massachusetts and file electronic reports to the Massachusetts Department of Revenue in a manner consistent with the requirements under the Massachusetts Health Care Reform Act? Yes No

If no: The Employer acknowledges it will provide written statements and electronic reporting to the Massachusetts Department of Revenue if required by the Massachusetts Health Care Reform Act.

3. Alternative Care Management Program (applicable to the purchased medical management program):

Yes No

The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons for Utilization Management, Case Management, including but not limited to Behavioral Health, and other health care management programs.

4. Prior Authorization (applicable to the purchased medical management program): Employer acknowledges and agrees to utilize Claim Administrator's standard list of services and supplies for which Prior Authorization (also called pre-notification or preauthorization) is required.

5. Essential Health Benefits ("EHB") Election:

Employer elects EHBs based on the following:

1. EHBs based on a Claim Administrator state benchmark:
 Illinois Montana New Mexico Oklahoma Texas
2. EHBs based on benchmark of a state other than IL, MT, NM, OK and TX
 If so, indicate the state's benchmark that Employer elects: ____
3. Other EHB, as determined by Employer

In the absence of an affirmative selection by Employer of its EHBs, then Employer is deemed to have elected the EHBs based on the Illinois benchmark plan.

6. This ASO BPA is binding on both parties and is incorporated into and made a part of the Administrative Services Agreement between the parties with both such documents to be referred to collectively as the "Agreement" unless specified otherwise.

7. Producer/Consultant Compensation:

The Employer acknowledges that if its POR acts on its behalf for purposes of purchasing services in connection with the Employer's Plan under the Administrative Services Agreement to which this ASO BPA is attached, the Claim Administrator may pay the Employer's POR a commission and/or other compensation in connection with such services under the Agreement. If the Employer desires additional information regarding commissions and/or other compensation paid to the POR by the Claim Administrator in connection with services under the Administrative Services Agreement, the Employer should contact its POR.

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Additional Provisions: Effective 01/01/2022:

BA0003 / BA0004:

- Moving to Performance Drug List
- Adding APR shared savings
- Adding multi split RX

Wellness Credit: BCBSIL will provide a one-time wellness credit of \$75,000 for the twelve-month period beginning on the Contract Effective Date, to be used to cover costs and expenses associated with implementation and/or operation of a wellness program. [For ERISA plans: Employer is accepting the wellness credit on behalf of the wellness program, which is or is part of an ERISA plan. Employer hereby certifies that it will only use it for purposes consistent with the administration of the plan.] If Employer cancels coverage before expiration of the policy period, Employer will be required to refund BCBSIL the full amount of the wellness credit.

The Admin charges shown in this BPA reflect a volume-based discount in an amount up to \$1.50 PEPM for the twelve month period beginning on the contract effective date. If the ancillary coverage (Life, AD & D, LTD) lapses during this twelve-month period, BCBSIL reserves the right to remove the volume-based discount on the medical premium. In such event, upon sixty (60) days prior written notice to Employer, the premium payment will revert to the non-discounted amount.

Proprietary and Confidential Information of Claim Administrator

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Signature

Dee Mastro Holzkopf

Sales Representative

890

630-824-5558

District

Phone & FAX Numbers

Producer Representative

The Horton Group

Producer Firm

10320 Orland Parkway, Orland Park, IL

Producer Address

Producer Phone & FAX Numbers

Producer Email Address

36-3672171

Tax I.D. No.

Signature of Authorized Purchaser

Print Name

Title

Date

Proprietary and Confidential Information of Claim Administrator

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PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members is scheduled to be held each year in the HCSC corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice provided to the member not less than thirty (30) nor more than sixty (60) days prior to such meetings. This proxy shall remain in effect until either revoked in writing by the undersigned at least twenty (20) days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

From time to time, HCSC pays indemnification or advances expenses to its directors, officers, employees or agents consistent with HCSC's bylaws then in force and as otherwise required by applicable law.

Group No.: P65060 By: _____
P65061 _____
 Print Signer's Name Here
 → _____
 Signature and Title

Group Name: Village of Downers Grove

Address: 801 Burlington Avenue

City: Downers Grove State: IL ZIP: 60515

Dated this _____ day of _____

 Month Year

Proprietary and Confidential Information of Claim Administrator

Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

PBM Fee Schedule Addendum to the Benefit Program Application

Village of Downers Grove	
Term: 01/01/2022-12/31/2022	Employees: 395
Guaranteed Traditional Aggregate Pricing Arrangement D ^{1*} Advantage Network and Performance Drug List	
RETAIL	
Brand	Generic
AWP minus	AWP minus
20.20%	83.20%
DISPENSING FEE	
Brand	Generic
\$0.45	\$0.45
MAIL	
Brand	Generic
AWP minus	AWP minus
22.75%	82.25%
DISPENSING FEE:	\$0.00
EXTENDED SUPPLY NETWORK ("ESN") (If Applicable)	
Brand	Generic
AWP minus	AWP minus
22.75%	85.40%
DISPENSING FEE:	\$0.00
Aggregate Specialty Discount	
Pricing based on Employer's use of the Prime Specialty network	AWP minus: 18.90%
DISPENSING FEE:	\$0.00
Rebate Credits to Employer:	
PEPM Rebate Credits to Employer:	\$73.66
Employer Administration Fees:	
PBM Administration Fees PEPM:	\$0.00

Additional Provisions:

¹ Employer will be billed for retail brand and retail generic prescriptions, mail brand and mail generic prescriptions, ESN brand and ESN generic, and Specialty pharmacy claims (excluding compound prescriptions) based on the lesser of (a) U&C or (b) PBM's adjudication rate schedule(s) that is/are intended to achieve, on an aggregate calendar-year basis, the AWP discounts and Dispensing Fees shown above for all of Claim Administrator's group customers that have purchased the above specific pricing arrangement ("Groups with the Pricing Arrangement") and use the above Network (the "Employer's Contract Rates").

For purposes of setting Employer's Contract Rates and calculating whether the AWP discounts and Dispensing Fees have been achieved:

- a. Brand drugs are defined as all drugs that have a Medi-Span multisource code field equal to "M", "N", or "O".
- b. Generic drugs are defined as all drugs available in sufficient supply that have a Medi-Span multisource code field equal to "Y".

Employer acknowledges and agrees that Employer's Contract Rates may vary based on market influences and as necessary to achieve the AWP discounts and Dispensing Fees shown above, on an aggregate calendar year basis, for Groups with the Pricing Arrangement that use the above Network. However, such variation for Brand products in each of the Retail, Mail, and ESN categories (on an aggregate annual basis) may only vary by +/-3% from the applicable AWP discount shown above.

Employer will be billed the above Dispensing Fee (such Fee may be included in the amount billed to Employer) unless the Employer is billed based on the U&C price. If the Employer is billed based on the U&C price, then the Dispensing Fee is included in such U&C price.

Employer will be billed for Compound Drug claims based on the applicable discounted rate in the Network Contract.

Employer will be billed for Foreign Claims based on an amount equal to the amount billed by the pharmacy.

Employer will be billed for out-of-network claims based on the pricing set forth in the Administrative Services Agreement and/or PBM Exhibit, as applicable.

If the AWP discounts and Dispensing Fees shown above are not achieved for a particular calendar year, for Groups with the Pricing Arrangement that use the above Network, then Employer will be credited, no later than 180 days after the end of each calendar year during the Term, an amount calculated as follows:

- First, the total aggregate shortfall dollar amount for the calendar year for Groups with the Pricing Arrangement that use the above Network will be calculated by comparing the actual performance of each of the above categories (Retail, Mail, ESN, and Specialty) with the corresponding AWP discounts and Dispensing Fees shown above for each category. The amount of any performance in any category that exceeds the above AWP discounts and Dispensing Fees will be used to offset any and all shortfall(s) in any or all categories. The above aggregate shortfall, if any, is then divided by total claims for Groups with the Pricing Arrangement that use the above Network, and did not terminate their Addendum prior to their anniversary date, for the calendar year ("Per Claim Amount"). Then the Per Claim Amount will be multiplied by Employer's total claims for that calendar year to calculate the reconciliation credit. However, if Employer terminates this Addendum prior to its anniversary date and the above Guaranteed Traditional Aggregate Pricing Arrangement is not achieved, then Employer will not be eligible to receive such credit.
- For purposes of determining if a shortfall exists, claims billed to Employer based on the U&C price will be considered to have \$0.00 Dispensing Fees.
- Compound Drug claims, Foreign Claims, reversed claims, and out-of-network claims are excluded from the calculation of whether the AWP discounts and Dispensing Fees shown above have been achieved and also are excluded from the calculation of any shortfall credit for Employer.
- If the AWP discounts and Dispensing Fees shown above are exceeded for Groups with the Pricing Arrangement that use the above Network, then Employer will not receive any credit, and there will not be a year-end settlement.

HCSC GEN ASO Traditional PBM Fee Addendum 6.19

- Under the Guaranteed Traditional Aggregate Pricing Arrangement any particular group customer’s experience relative to the pricing guarantees will not determine its eligibility for a credit. Group customer’s eligibility for a credit is determined based on the aggregate experience of all group customers that have purchased the Pricing Arrangement and use the above Network. As such, an individual group customer may have experience that does not meet, or exceeds, the AWP discounts and Dispensing Fees shown above. In addition, when there is a reconciliation credit, it is allocated in a manner described above and not based on any particular group’s experience (other than number of claims).

PBM uses Medi-Span as the pricing source to establish AWP, for purposes of calculating whether the above AWP discounts have been achieved.

Members’ cost share is the applicable copayment, deductible, and/or coinsurance, which coinsurance is calculated based on the Employer’s Contract Rate or the applicable out-of-network pricing. Zero balance logic is not employed.

AWP discounts are based on the actual NDC-11 dispensed.

AWP discounts do not include savings from drug utilization review or other clinical or medical management programs.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees may be subject to change if the Employer’s claims include 340B pricing.

In addition to the rights of the parties under the PBM Exhibit, if changes occur within the pharmacy benefit management marketplace which lead to a significant deviation from the current economic environment, both parties agree to engage in good faith negotiations to amend this Addendum to make impact on both parties commercially reasonably economically neutral. If the parties cannot agree on the terms of the amendment, either party shall be allowed to (a) proceed to dispute resolution, as set forth in the Administrative Services Agreement or (b) terminate this Addendum with 90 days’ prior written notice to the other party. Failure to reach agreement on the amendment shall not be a breach of contract.

The above Guaranteed Traditional Aggregate Pricing Arrangement, Rebate Credits and Administrative Fees are based on the Network and Drug List shown above.

Unless otherwise specified in this Addendum, capitalized terms used in this Addendum shall have the meanings set forth in the Administrative Services Agreement or the PBM Exhibit, as applicable.

* Employer Payments to Claim Administrator for Covered Services provided by Network Participants are calculated based on the pricing terms set forth in this Addendum which shall remain in effect for the term of this Addendum to the extent described in the Administrative Services Agreement. Such pricing may or may not equal the amounts actually paid to the Network Participants or received from drug manufacturers (e.g., rebates), or the amounts paid or received between Claim Administrator and the PBM. As a result, the PBM or Claim Administrator may realize positive margin on prescriptions filled at retail, mail order, ESN or specialty pharmacies or prescription drug rebates. Employer acknowledges that it has negotiated for the specific traditional pricing terms set forth in this Addendum, and that it and its group health plan have no right to, or legal interest in, any portion of any positive margin retained by Claim Administrator or PBM and consents to Claim Administrator’s and PBM’s retention of all such amounts.

Signature of Authorized Purchaser

Print Name

Title

Date